3955L.01I

AN ACT

To repeal sections 208.152, 208.204, and 630.210, RSMo, and to enact in lieu thereof four new sections relating to the children's mental health reform act.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 208.152, 208.204, and 630.210, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 208.152, 208.204, 630.097, and 630.210, to read as follows:

208.152. 1. Benefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in boldface type in the above law is proposed language.

children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the division of aging or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX, of the federal

Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for recipients of benefit payments under subdivision (4) of this section for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Dental services;

(8) Services of podiatrists as defined in section 330.010,

RSMo;

(9) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;

(10) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments. The department of social services may conduct demonstration projects related to the provision of medically necessary transportation to recipients of medical assistance under this chapter. Such demonstration projects shall be funded only by appropriations made for the purpose of such demonstration projects. If funds are appropriated for such demonstration projects, the department shall submit to the general assembly a report on the significant aspects and results of such demonstration projects;

(11) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of section 6403 of P.L.53 101-239 and federal regulations promulgated thereunder;

(12) Home health care services;

(13) Optometric services as defined in section 336.010, RSMo;

(14) Family planning as defined by federal rules and

regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the Medicaid agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(15) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(16) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(17) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(18) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care

facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

(19) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097, RSMo.

(a) The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an

alcohol and drug abuse facility. Such mental health services shall include:

[(a)**]** a. Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

[(b)**]** b. Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

[(c)**]** c. Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol

and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, division of medical services, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the division of medical services. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(b) The department of mental health, in collaboration with the department of social services, shall establish by rule the definition and criteria for designation of a community-based service. Services to be made available and easily accessible include intensive home-based services, early intervention services, family support services, respite services, and behavioral assistance services;

(20) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and

monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function. The division of medical services shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism;

(21) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Such additional services as defined by the division of medical services to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(23) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

(24) Subject to appropriations, the department of social services shall conduct demonstration projects for nonemergency, physician-prescribed transportation for pregnant women who are recipients of medical assistance under this chapter in counties selected by the director of the division of medical services. The funds appropriated pursuant to this subdivision shall be used for the purposes of this subdivision and for no other purpose. The department shall not fund such demonstration projects with revenues received for any other purpose. This subdivision shall not authorize transportation of a pregnant woman in active labor. The division of medical services shall notify recipients of nonemergency transportation services under this subdivision of such other transportation services which may be appropriate during active labor or other medical emergency;

(25) Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection to reserve a bed for the recipient in the nursing home during the time that the recipient is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the division of aging which was taken prior to when the recipient is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the recipient or the

recipient's responsible party that the recipient intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the recipient or the recipient's responsible party prior to release of the reserved bed.

2. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

3. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for dental services, drugs and medicines, optometric services, eye glasses, dentures, hearing aids, and other services, to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or

services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be in addition to, and not in lieu of, any payments made by the state for goods or services described herein.

4. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children

below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the Medicaid program shall not increase payments in excess of the increase that would result from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The department of social services, division of medical services, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

208.204. 1. The division of medical services may administer the funds appropriated to the department of social services or any division of the department for payment of medical

care provided to children in the legal custody of the department of social services or any division of the department.

2. The department of social services shall review all cases of children in their custody to determine which cases involve children in the system due exclusively to a need for mental health services and identify the cases where no instance of abuse, neglect, or abandonment exists.

3. Within sixty days of a child being identified pursuant to subsection 2 of this section, an individualized treatment plan shall be submitted to the court for approval and developed by the applicable state agencies responsible for providing or paying for any and all appropriate and necessary services, subject to appropriation, and shall specifically identify which agencies are going to pay for and provide such services. Services shall be provided in the least restrictive, most appropriate environment that meets the needs of the child including home and community-based support and treatment. The child's family shall actively participate in designing the service plan for the child. The department of social services shall notify the appropriate judge of the child and shall submit the service plan developed for approval by the judge. The child may be returned by the judge to the custody of the child's family.

4. When the children are returned to their family's custody and become the service responsibility of the department of mental health, the appropriate moneys to provide for the care of each

child in each particular situation shall be billed to the department of social services by the department of mental health pursuant to a comprehensive financing plan jointly developed by the two departments.

630.097. 1. The department of mental health shall develop, in conjunction with all departments represented on the children's services commission, a unified accountable comprehensive children's mental health service system. There shall be an executive board consisting of the appropriate department directors. The department of mental health shall establish a state interagency comprehensive children's mental health service system team to serve children with emotional and behavioral disturbance problems, developmental disabilities, and substance abuse problems. The team shall be comprised of representation from:

(1) The department of health and senior services;

(2) The department of social services' children's division, division of youth services, and the division of medical services;

(3) The department of elementary and secondary education;

(4) The department of mental health's division of alcohol and drug abuse, division of mental retardation and developmental disabilities, and the division of comprehensive psychiatric services;

(5) The department of public safety;

(6) The office of state courts administrator;

(7) The juvenile justice system; and

(8) Family members;

The team shall be called "The Comprehensive System Management Team". There shall be a stakeholder implementation advisory committee to provide input to the comprehensive system management team to assist the state departments in developing strategies and to ensure positive outcomes for children are being achieved. The department of mental health shall obtain input from appropriate consumer and family advocates, in consultation with the departments that serve on the children's services commission, when selecting family members for the comprehensive system management team. The implementation of a comprehensive system shall include all state agencies and system partner organizations involved in the lives of the children served. These system partners may include private and not-for-profit organizations, who may serve on the stakeholder implementation advisory committee pending approval by the departments represented on the children's services commission.

2. The department of mental health, in conjunction with the departments serving on the children's services commission and the stakeholder implementation advisory committee, shall develop a state comprehensive children's mental health service system plan. This plan shall be developed and submitted to the governor, house of representatives, senate, and children's services commission by

December 31, 2004. The plan shall define outcomes, progress toward outcomes, and plans to monitor progress.

3. The comprehensive system management team shall collaborate to develop uniform language to be used in intake, assessment, and other tools to be used with children.

4. The comprehensive children's mental health services system shall:

(1) Be child centered, family focused, and family driven, with the needs of the child and family dictating the types and mix of service provided, and shall include the families as full participants in all aspects of the planning and delivery of services;

(2) Provide community-based mental health services to children and their families in the context in which the children live and attend school;

(3) Respond in a culturally competent and responsive manner;

(4) Stress prevention and early identification and intervention;

(5) Assure access to a continuum of services that:

(a) Educate the community about the mental health needs of children;

(b) Address the unique physical, emotional, social, developmental, and educational needs of children;

(c) Are coordinated with the range of social and human

services provided to children and their families by local school districts, social services, health and senior services, public safety, and the family courts;

(d) Provide a comprehensive array of services through an individualized service plan;

(e) Provide services in the least restrictive most appropriate environment that meets the needs of the child; and

(f) Are appropriate to the developmental needs of children;

(6) Include early screening and prompt intervention to:

(a) Identify and treat the mental health needs of children in the least restrictive environment appropriate to their needs; and

(b) Prevent further deterioration;

(7) Address the unique problems of paying for mental health services for children, including:

(a) Access to private insurance coverage;

(b) Public funding; and

(c) Private funding and services;

(8) Include the child and the child's family in all aspects of planning, service delivery, and evaluation;

(9) Assure a smooth transition from child to adult mental services when needed;

(10) Coordinate a service delivery system inclusive of services, providers, and schools that serve children and youth with emotional and behavioral disturbance problems, and their

families through state agencies that serve on the state comprehensive children's management team; and

(11) The system shall be outcome based.

5. An independent evaluation shall be completed and distributed to the general assembly.

630.210. 1. The director shall determine the maximum amount for services which shall be charged in each of the residential facilities, day programs or specialized services operated or funded by the department for full-time or part-time inpatient, resident or outpatient evaluation, care, treatment, habilitation, rehabilitation or other service rendered to persons affected by mental disorder, mental illness, mental retardation, developmental disability or drug or alcohol abuse. The maximum charge shall be related to the per capita inpatient cost or actual outpatient evaluation or other service costs of each facility, program or service, which may vary from one locality to another. The director shall promulgate rules setting forth a reasonable standard means test which shall be applied by all facilities, programs and services operated or funded by the department in determining the amount to be charged to persons receiving services. The department shall pay, out of funds appropriated to it for such purpose, all or part of the costs for the evaluation, care, treatment, habilitation, rehabilitation or room and board provided or arranged by the department for any patient, resident or client who is domiciled in Missouri and who

is unable to pay fully for services.

2. The director shall apply the standard means test annually and may make application of the test upon his own initiative or upon request of an interested party whenever evidence is offered tending to show that the current support status of any patient, resident or client is no longer proper. Any change of support status shall be retroactive to the date of application or request for review. If the persons responsible to pay under section 630.205 or 552.080, RSMo, refuse to cooperate in providing information necessary to properly apply the test or if retroactive benefits are paid on behalf of the patient, resident or client, the charges may be retroactive to a date prior to the date of application or request for review. The decision of the director in determining the amount to be charged for services to a patient, resident or client shall be final. Appeals from the determination may be taken to the circuit court of Cole County or the county where the person responsible for payment resides in the manner provided by chapter 536, RSMo.

3. The department shall not pay for services provided to a patient, resident or client who is not domiciled in Missouri unless the state is fully reimbursed for the services; except that the department may pay for services provided to a transient person for up to thirty days pending verification of his domiciliary state, and for services provided for up to thirty days in an emergency situation. The director shall promulgate

rules for determination of the domiciliary state of any patient, resident or client receiving services from a facility, program or service operated or funded by the department.

4. Whenever a patient, resident or client is receiving services from a residential facility, day program or specialized service operated or funded by the department, and the state, county, municipality, parent, guardian or other person responsible for support of the patient, resident or client fails to pay any installment required to be paid for support, the department or the residential facility, day program or specialized service may discharge the patient, resident or client as provided by chapter 31, RSMo. The patient, resident or client shall not be discharged under this subsection until the final disposition of any appeal filed under subsection 2 of this section.

5. The standard means test may be waived for a child in need of mental health services to avoid inappropriate custody transfers to the children's division. The department of mental health shall notify the child's parent or custodian that the standard means test may be waived. The department of mental health shall promulgate rules for waiving the standard means test. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter

536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.